Testimony of

Daniel Perry
Executive Director

Alliance for Aging Research

before

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Chairman Craig, Senator Breaux and distinguished members of the Special Committee on Aging, thank you for this opportunity to address the prevalence of ageism in American health care.

Senator Breaux, last fall you also presided over a hearing of this Committee raising awareness about the bias against older people in other aspects of American society, especially in the way they are portrayed by the media. Today's hearing appropriately focuses on health care, where ageist assumptions of what is good for older patients can have momentous consequences.

The Alliance for Aging Research is a not-for-profit organization, working to ensure that older Americans receive quality health care, informed by best geriatric practices, as well as have access to the newest and most effective medications, treatments, therapies and medical technologies, without any discrimination based on age.

Today the Alliance is releasing a new report titled ***How American Health Care Fails Older Americans***. This is the second time in ten years that our organization has raised evidence of a systematic medical bias against the elderly. Once again we are citing scores of current and recent scientific studies, reports, surveys and medical commentaries to make our point.

Ageism is a deep and often-unconscious prejudice against the old, an attitude that permeates American culture. It is a particularly apparent and especially damaging frame of mind that surfaces all too often in healthcare settings where older patients predominate. Like other patterns of bias – such as racism and sexism – these attitudes diminish us all, but they can be downright deadly to older people in receiving healthcare.

In the Alliance's latest report we document how older patients too often do not receive preventive treatments such as vaccines and screening tests that could potentially prevent diseases from becoming life threatening. Indeed, due to insufficient research on older patients, there is very little clinical agreement what constitutes normal lab results in older people.

Lack of generally accepted standards of care for geriatric patients means older patients are more likely to face inappropriately invasive procedures, such as multiple heart surgeries, while others are may be denied a life-saving surgery out of the mistaken concern that the patient's age alone rules them out for certain procedures.

Medical neglect of the aged often begins even before illness strikes. It starts with the failures to screen older people for the early signs of incipient disease. Very few screening guidelines have been developed that even refer to people over age 65, even though the vast majorities of fatal heart attacks and cancer deaths occur after that age. We are still waiting for the research to show whether common health screening protocols for measuring cholesterol or colorectal cancer exams catch problems early enough in the elderly to save lives.

The short shrift given to older people begins even earlier, with the training of America's health professionals – or more accurately the *lack* of training in the basics of good geriatric medicine. Only about 1 in 10 U.S. medical schools requires a rotation or substantial coursework in geriatrics for physicians in training. Our schools of nursing, pharmacy and

other allied health professions do no better, with less than 1% of the accredited professionals in those field having advanced work in geriatrics. The fact that so few U.S. pharmacists are specifically trained in geriatric pharmacology likely contributes to frequent over-medication, under-medication, and mis-medication of the elderly, a serious and growing public health problem.

Until a few years ago there was only one medical school in the U.S. with a full Department of geriatric medicine. Then, thanks to the leadership of the Donald W. Reynolds Foundation and a couple of state governments, that number increased to three very recently. And now, within the past year, newly inaugurated Departments of geriatrics in Florida and Hawaii raise the number to five. That may be some progress, but 5 Departments of geriatrics out of 145 allopathic and osteopathic medical colleges in the U.S. is still embarrassingly few.

Scant exposure to the principles of goods geriatric medicine can foster ageist assumptions that "it's too late" to change the health habits or older people, or worse, that serious and chronic health problems in older patients are a "natural" and therefore acceptable part of the aging process. Our report cites a survey of physicians involved in health care of the elderly in which 35 percent of doctors considered elevated blood pressure to be a normal process of aging and 25 percent considered treating hypertension in an 85-year-old patient to have more risks than benefits.

In our report we cite authoritative studies demonstrating that too little effort is made at preventive care in the elderly, despite proven advantages for improving quality of life. We call attention to ageist, defeatist attitudes when it comes to counseling older smokers to quit the tobacco habit, or to engage in regular physical activity. When it comes to standard HIV/AIDS

treatment and prevention efforts as well as substance abuse protocols, there is a blind spot born of ageism when it comes to people in their 60s and older.

Our report also notes that older people are systematically excluded or discouraged from participating in the clinical trials that determine the safety and efficacy of new therapeutic drugs, even though older people predominate as the end users of pharmaceutical therapies. That means many of the side effects and other attributes of these drugs are not recognized until they may have harmed some older patients following approval and marketing.

The bias that underlies these shortcomings would be unacceptable if the elderly were a small percentage of the patient population in our country. But currently Americans over the age of 65 comprise half of all physician time. By 2030, almost 1 in 4 of the entire population of the U.S. will be in this age group. Ageist assumptions that distort the quality of healthcare for such as large and growing group hurt everyone, because they lead to premature loss of independence on a giant scale, and they increase mortality, disability and depression in older adults who might otherwise lead productive, satisfying and healthier lives.

Older people themselves often unconsciously embrace unfounded assumptions that to be old is to be sick, that they shouldn't "bother" their physician by bringing up health concerns, or that "you can't teach and old dog new tricks," regarding changing health behaviors.

Mr. Chairman, we thank the Special Committee for its attention to ageism in healthcare as a threat to the well being of older Americans. Ageism is not something that we can just accept or ignore, and unfortunately, and it is not something that will just go away. However, the Alliance's report does submit these key recommendations for getting to the root of the problem:

- There should be reform of medical and healthcare professional education so that every doctor, nurse and allied health provider has received some training in geriatrics prior to graduation;
- Researchers should target studies on the benefits to older people of common health screening protocols and preventive measures; Medicare and private insurance should help educate providers and patients alike on benefits established by medical evidence;
- Congress and health agencies should raise awareness of the availability of experimental drug trials and consider legislation creating appropriate incentives to include older subjects in clinical trials;
- We should all work to educate and empower older adults and their families to be effective advocates in healthcare delivery that too often fails the elderly.

Thank you.